

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

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OMB No. :0939-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: North Carolina

CASE MANAGEMENT SERVICES
INDIVIDUALS WITH A DEVELOPMENTAL DISABILITY

- A. Target Group: Individuals with a developmental disability who meet the criteria in Attachment 1.
- B. Areas of State in which services will be provided:
- X Entire State.
- Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide service less than Statewide:
- C. Comparability of Services
- Services are provided in accordance with section 1902 (a)(10)(B) of the Act.
- X Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.
- D. Definition of Services: Services are defined in Attachment 1.
- E. Qualification of Providers: Qualifications of providers are described in Attachment 1.

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State/Territory: North Carolina

- F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.
 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

TN. No. 89-04

Supersedes

TN. No. N/A

Approval Date DEC 06 1989

Eff. Date 7/1/89

Case Management Services
Individuals with Developmental Disabilities

A. Target Group

Individuals with developmental disabilities for whom Medicaid case management services may be provided must meet the following criteria:

1. Children less than three years of age who are at risk for developmental delay/disability, social-emotional disorder or a severe chronic illness (conditions which would pre-dispose a child to severe chronic illness).
2. Children less than five years of age who have a diagnosed developmental delay, social-emotional disorder or severe chronic illness (a physical condition which is likely to continue indefinitely, interferes with daily routine, and requires extensive medical intervention and extensive family management).
3. Case management under this proposal will not be provided to home and community-based waiver participants nor institutionalized persons.

D. Definition of Services

Case management services include:

1. Assessment and periodic reassessment to determine types and amounts of services needed;
2. Development and implementation of an individualized case management service plan with the client;
3. Consistent with SSA 1902(a)(23), coordination and assignment of responsibilities among staff and service agencies; and
4. Monitoring and follow-up to ensure that services are received and are adequate for the client's needs.

E. Qualification of Providers

Targeted Case Management Services for persons described in A. "Target Group" are under the jurisdiction of the state Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) or the state Division of Public Health (DPH).

1. Enrolled providers under the jurisdiction of DMH shall meet the qualifications in (a), (b) and (c).
 - (a) Must have qualified case managers. Case Managers are professionals whose education, skills, abilities, and experience enable them to perform the activities that comprise Medicaid case management services. Qualified case managers shall meet the qualifications in (i) or (ii).
 - (i) Be a qualified Developmental Disabilities Professional (QDDP) as defined below;

An individual holding at least a baccalaureate degree in a discipline related to developmental disabilities and at least two years of supervised habilitative experience by a QDDP in working with the mentally retarded or otherwise developmentally disabled or hold a baccalaureate degree in a field other than one related to developmental disabilities and have three years of supervised experience in working with the mentally retarded or otherwise developmentally disabled; or,
 - (ii) Be supervised by a qualified developmental disabilities professional and meet the following education and experience requirements:
 - (1) Have at least a baccalaureate degree in a field other than one related to developmental disabilities with a QDDP signed off on case management work; or,
 - (2) For children under 18, a licensed registered nurse must have two years experience in nursing, which includes working with children and families.

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- (b) Must meet applicable state and federal laws governing the participation of providers in the Medicaid program.
- (c) Must be certified by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services as a qualified case management provider.

Enrollment is open to all providers who can meet these requirements. An agreement will be made with the Division of Mental Health, Developmental Disabilities, Substance Abuse Services, which has the recognized professional expertise and authority to establish standards that govern case management services for them. The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services will certify that providers are qualified to render case management services in accordance with state standards or other professionally recognized standards for good care. The purpose of this activity is to help assure that case management services are provided by professionally qualified providers in accordance with Section 1902(a)(23) of the Act.

The Division of Mental Health, Developmental Disabilities, Substance Abuse Services through an MOU with the Division of Medical Assistance will implement methods and procedures to certify all providers for case management to persons described in A. "Targeted Group" who can demonstrate:

- (i) Their capacity to provide case management services.
- (ii) Their experience with delivery and/or coordination of services for persons described in A. "Target Group".
- (iii) Their Capacity to assure quality.
- (iv) Their experience in sound financial management and record keeping.

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2. Enrolled providers under the jurisdiction of DHHS shall meet the qualifications in (a), (b) and (c).
- (a) Must have qualified case manager(s).
- Case Manager Qualifications:
- (i) MS in a Human Service Area that includes Social Work, Sociology, Special Education, Child Development, Psychology or Nursing. As applicable, licensed.
 - (ii) BS in Human Service Area that includes the above disciplines. Licensed as applicable and 2 years experience in working with children and their families.
 - (iii) licensed RN with 2 years experience in working with children and their families.
- (b) Must meet applicable state and federal laws governing the participation of providers in the Medicaid program.

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- (c) Must be certified by the Division of Public Health as a qualified case management provider.

Enrollment is open to all providers who can meet these requirements. An agreement will be made with the Division of Public Health, which has the recognized professional expertise and authority to establish standards that govern case management services for them. The Division of Public Health will certify that providers are qualified to render case management services in accordance with state standards or other professionally recognized standards for good care. The purpose of this activity is to help assure that case management services are provided by professionally qualified providers in accordance with Section 1902(a)(23) of the Act.

The Division of Public Health through an MOU with the Division of Medical Assistance will implement methods and procedures to certify all providers for case management to persons described in A. "Target Group" who can demonstrate:

- (i) Their capacity to provide case management services.
- (ii) Their experience with delivery and/or coordination of services for persons described in A. "Target Group".
- (iii) Their capacity to assure quality.

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- (iv) Their experience in sound financial management and record keeping.
- 3. The term jurisdiction means the lead State agency responsible for establishing the case management provider expectations and developing the delivery system for the client population to be served.

TN No. 89-04
Supercedes
TN No. N/A

Approval Date **DEC 06 1989**

Eff. Date 7/1/89

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: North Carolina

“CASE MANAGEMENT SERVICES FOR ADULTS AND CHILDREN AT-RISK OF ABUSE,
NEGLECT, OR EXPLOITATION”

A. Target Group:

At-risk adults and children who meet the criteria shown in Attachment 1, Item A.

B. Areas of State in which services will be provided:

X Entire State.

— Only in the following geographic areas (authority of section 1915(g)(1)
of the Act is invoked to provide services less than Statewide:

C. Comparability of Services:

— Services are provided in accordance with section 1902(a)(10)(B)
of the Act.

X Services are not comparable in amount, duration, and scope.
Authority of section 1915(g)(1) of the Act is invoked to provide
services without regard to the requirements of section 1902(a)(10)(B)
of the Act.

D. Definition of Services:

Services are defined in Attachment 1, Item D.

E. Qualification of Providers:

Qualifications of providers are described in Attachment 1, Item E.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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“CASE MANAGEMENT SERVICES FOR ADULTS AND CHILDREN AT-RISK OF ABUSE, NEGLECT,
OR EXPLOITATION”

- F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.
 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

TN No. 92-15
Supersedes
TN NO. NEW

Approval date **FEB 25 1993**

Eff. Date 10/1/92

ATTACHMENT 1 TO SUPPLEMENT 1
OF ATTACHMENT 3.1-A PART F

“CASE MANAGEMENT SERVICES FOR ADULTS AND CHILDREN AT-RISK OF ABUSE, NEGLECT, OR EXPLOITATION”

- A. Target Group: The target group includes Medicaid recipients who are assessed as at-risk of abuse, neglect, or exploitation as defined in North Carolina General Statutes 7A-517 and 108A-101. The recipient cannot be institutionalized nor a recipient of other Medicaid-reimbursed case management services provided through the State’s home and community-based services waivers or the State Plan. The recipient must reside in a county designated by the Division of Medical Assistance to offer this service. The case manager assesses risk using a State prescribed format. The criteria for determining whether an adult or child is at-risk of abuse, neglect, or exploitation is as follows:
1. At-Risk Adult: An at-risk adult is an individual who is at least 18 years old, or an emancipated minor, and meets one or more of the following criteria:
 - a. An individual with only one consistent identified caregiver, who needs personal assistance 24 hours per day with two or more of the activities of daily living (bathing, dressing, grooming, toileting, transferring, ambulating, eating, communicating); or
 - b. An individual with no consistent identified caregiver, who is unable to perform at least one of the activities of daily living (bathing, dressing, grooming, toileting, transferring, ambulating, eating, communicating); or
 - c. An individual with no consistent identified caregiver, who is unable to carry out instrumental activities of daily living (managing financial affairs, shopping, housekeeping, laundry, meal preparation, using transportation, using a telephone, reading, writing); or
 - d. An individual who was previously abused, neglected or exploited, and the conditions leading to the previous incident continue to exist; or
 - e. An individual who is being abused, neglected, or exploited and the need for protective services is substantiated.
 2. At-Risk Child: An at-risk child is an individual under 18 years of age who meets one or more of the following criteria:
 - a. A child with a chronic or severe physical or mental condition whose parent(s) or caretaker(s) are unable or unwilling to meet the child’s care needs or whose adoptive parents needs assistance in order to meet the child’s care needs; or
 - b. A child whose parents are mentally or physically

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impaired to the extent that there is a need for assistance with maintaining family stability and preventing or remedying problems which may result in abuse or neglect of the child; or

- c. A child of adolescent (under age 18) parents or parents who has their first child when either parent was an adolescent and there is a need for assistance with maintaining family stability, strengthening individual support systems, and preventing or remedying problems which may result in abuse or neglect of the child; or
- d. A child who was previously abused or neglected, and the conditions leading to the previous incident continue to exist; or
- e. a child who is being abused or neglected and the need for protective services is substantiated.

D. Definition of Services: Case management is a set of interrelated activities under which responsibility for locating, coordinating, and monitoring appropriate services for an individual rests with a specific person or organization. The purpose of case management services for adult and children at-risk of abuse, neglect, or exploitation is to assist them in gaining access to needed medical, social, educational, and other services; to encourage the use of cost-effective medical care by referrals to appropriate providers; and to discourage over-utilization of costly services. Case management services will provide necessary coordination with providers of non-medical services such as nutrition programs like WIC or educational agencies, when services provided by these entities are needed to enable the individual to benefit from programs for which he or she is eligible.

The set of interrelated activities are as follows:

- 1. Evaluation of the client's individual situation to determine the extent of or need for initial or continuing case management services.
- 2. Needs assessment and reassessment to identify the service needs of the client.
- 3. Development and implementation of an individualized plan of care to meet the service needs of the client.
- 4. Providing assistance to the client in locating and referring him or her to providers or programs that can meet the service needs.
- 5. Coordinating delivery of services when multiple providers or programs are involved in care provision.

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6. Monitoring and following-up to ensure services are received, adequate to meet the client's needs, and consistent with good quality of care.
- E. Qualifications of Providers: Enrollment of providers will be accomplished in accordance with section 1902(a)(23) of the Social Security Act.
1. Provider Qualifications – Providers must meet the following qualifications:
 - a. Meet applicable State and Federal laws governing the participation of providers in the Medicaid program.
 - b. Be certified by the Division of Social Services as a qualified case management provider.
 2. Certification Process - In the absence of State licensure laws governing the qualifications and standards of practice of providers of case management services for at-risk adults and children, the State Division of Medical Assistance and the State Division of Social Services have a Memorandum of Understanding to provide a certification process. The State Division of Social Services agrees to implement methods and procedures for certifying providers of case management services as qualified to render services according to professionally recognized standards for quality care. This will help assure that case management services are provided by qualified providers in accordance with section 1902(a)(23) of the Act.

To be certified, a provider must:

- a. Have qualified case managers with supervision provided by a supervisor who meets State requirements for Social Work Supervisor I or Social Work Supervisor II classification.

Case Manager for At-Risk Adults: A case manager for at-risk adults must have a Master of Social Work degree or a Bachelor of Social Work degree, or be a social worker who meets State requirements for Social Worker II classification. The individual must have training in recognizing risk factors related to abuse, neglect, or exploitation of elderly or disabled adults and in assessment of functional capacity and needs related to activities of daily living. The individual must have experience in providing case management for elderly and disabled adults.

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Case Manager for At-Risk Children: A case manager for at-risk children must have a Master of Social Work degree or a Bachelor of Social Work degree, or be a social worker who meets State requirements for Social Worker II classification. The individual must also have training in recognizing risk factors related to abuse or neglect of children and in assessing family functioning. The individual must have experience in providing case management for children and their families.

- b. Have the capability to access multi-disciplinary staff, when needed. For adults this includes, at a minimum, medical professionals as needed and an adult protective services social worker. For children, this includes, at a minimum, medical professionals as needed and a child protective services social worker.
- c. Have experience as a legal guardian of persons and property.

State Plan under Title XIX of the Social Security Act
State/Territory: North Carolina

CASE MANAGEMENT SERVICES
PERSONS WITH HIV DISEASE

- A. Target Group:
Persons who meet the criteria shown in Attachment 1, Item A.
- B. Areas of State in which services will be provided:
X Entire State.
- C. Comparability of Services:
X Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.
- D. Definition of Services:
Services are defined in Attachment 1, Item D.

Qualifications of Providers:

Qualifications are described in Attachment 1, Item E.
- F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

“Case Management Services for person with HIV disease”

A. Target Group

The target group includes individuals who:

1. Have a medical diagnosis of HIV disease; or
2. Have a medical diagnosis of HIV seropositivity; and
3. Are eligible for regular Medicaid services; and
4. Are not institutionalized; and
5. Are not recipients of other Medicaid-reimbursed case management services provided through the State's home and community-based services waivers or the State Plan.

D. Definition of Services

The components of HIV case management are listed below. In order to be reimbursed by the Division of Medical Assistance, a provider shall provide all of these components:

1. Evaluation of the client's situation to determine the need for initial case management services;
2. Comprehensive assessment of the client's assets, deficits and needs. The following areas must be addressed, when relevant:
 - a) Socialization/recreational needs,
 - b) Physical needs
 - c) Medical care concerns,
 - d) Social/emotional status,
 - e) Housing/physical environment status, and
 - f) Financial needs;
3. Development and implementation of a plan of care that includes goals, services to be provided and progress notes;
4. Coordination of service delivery when multiple providers or programs are involved in care provision;
5. Monitoring to ensure that services received meet the client's needs and are consistent with good quality of care;
6. Follow-up and reassessment to determine the continued appropriateness of services, the correct level of care, and the continued need for services;
7. Discharge of the client from services; and
8. Locating and helping access available systems, resources and services within the community to meet the client's needs.

E. Qualifications of Providers

1. Providers of HIV case management services shall:
 - a. Be enrolled in accordance with section 1902(a)(23) of the Social Security Act; and
 - b. Meet applicable State and Federal laws governing the participation of providers in the Medicaid program; and

“Case Management Services for person with HIV disease”

- c. Be certified by the AIDS Care Unit, Division of Public Health, Department of Health and Human Services (DHHS), as a qualified HIV case management provider.

2. Certification of Providers.

In the absence of State licensure laws governing the qualifications and standards of practice for HIV case management providers, the State Division of Medical Assistance and the AIDS Care Unit of the Division of Public Health, Department of Health and Human Services, have a Memorandum of Understanding for provision of a certification process. The AIDS Care Branch agrees to implement methods and procedures for certifying providers of HIV case management services as qualified to render services according to professionally recognized standards for quality care. This will ensure that HIV case management services are provided by qualified providers in accordance with section 1902(a)(23) of the Social Security Act.

To be certified, a provider must:

- a. Submit an application to the AIDS Care Branch that includes the provider’s plans for:
 - (i) Provision of all the HIV case management components in Attachment 1, Item D.; and
 - (ii) Quality assurance, including the monitoring and evaluation of case management records.
- b. Have qualified case managers who meet one of the following qualifications:
 - (i) Hold a master’s level degree in a human service area including, but not limited to, Social Work, Sociology, Child Development, Maternal and Child Health, Counseling, Psychology or Nursing; or
 - (ii) Hold a bachelor’s level degree in a human service area including, but not limited to, Social Work, Sociology, Child Development, Maternal and Child Health, Counseling, Psychology or Nursing and have two years experience working in human services; or
 - (iii) Be a licensed Registered Nurse, Nurse Practitioner, Physician Assistant, or Certified Substance Abuse Counselor and have two years experience working in human services; or

“Case Management Services for person with HIV disease”

- (iv) Have a high school diploma and two years experience providing case management services to clients with HIV disease. Persons who qualify under Attachment 1, Item E.(2)(b)(iv) shall have all their charts reviewed and signed by an HIV case management supervisor who meets the requirement under Attachment 1, Item E.(2)(c); and may serve as an HIV case manager for five years from date of employment as an HIV case manager in an agency certified to provide HIV case management. If an agency is not a certified HIV case management provider at the time of the person’s employment as an HIV case manager, the five year time period begins with the agency’s certification date. After the five year period ends, the person must meet HIV case manager requirements defined in Attachment 1, Item E. (2)(b)(i), (ii) or (iii) in order to continue providing HIV case management services.
- c. Have a qualified HIV case management supervisor who meets one of the following qualifications:
- (i) Master’s level degree in a human service area including, but not limited to, Social Work, Sociology, Child Development, Maternal and Child Health, Counseling, Psychology or Nursing and one year experience in case management; or
 - (ii) Bachelor’s level degree in a human service area including, but not limited to, Social Work, Sociology, Child Development, Maternal and Child Health, Counseling, Psychology or Nursing and two years experience in case management; or
 - (iii) Graduation from an accredited school of professional nursing and completion of three years of professional nursing experience, including two years in Public Health. Be licensed to practice as a registered nurse and have a minimum of two years experience in case management; or
 - (iv) Graduation from an accredited school of professional nursing and completion of three years of professional nursing experience, including two years experience supervising nurses responsible for developing and maintaining care plans and coordinating care and services for patients receiving care in their homes. Be licensed to practice as a registered nurse and have a minimum of two years experience in case management.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: North Carolina
CASE MANAGEMENT SERVICES

A. Target Group: All Children to Age 21 Who Are Eligible for EPSDT

B. Areas of State in which services will be provided:

X Entire State

— Only in the following geographic areas (authority of section 1915(g)(1) of the Act is involved to provide services less than Statewide:

C. Comparability of Services:

— Services are provided in accordance with section 1902 (a) (10)(B) of the Act.

X Services are not comparable in amount, duration, and scope. Authority of section 1915 (g) of the Act is involved to provide services without regard to the requirements of section 1901 (a) (10) (B) of the Act.

D. Definition of Services:

Case management is a set of interrelated activities under which responsibility for locating, coordinating and monitoring appropriate services for an individual rests with a specific person or organization. The purpose of case management services for children to age 21 is to assist those eligible for Medicaid in gaining access to needed medical, social, educational and other services, to encourage the use of cost-effective medical care by referrals to appropriate providers, and to discourage overutilization of costly services. Case management services will provide necessary coordination with providers of non-medical services such as nutrition programs like WIC or educational agencies, when services provided by these entities are needed to enable the individual to benefit from programs for which she is eligible.

The set of interrelated activities are as follows:

1. Evaluation of the clients' individual situation to determine the extent of or need for initial or continuing case management services.
2. Needs Assessment and reassessment to identify the service needs of the client.
3. Development and implementation of an individualized plan of care to meet the service needs of the client.
4. Providing assistance to the client in locating and referring her to providers and/or programs that can meet the service needs.

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5. Coordinating delivery of services when multiple providers or programs are involved in care provision.
6. Monitoring and follow-up to ensure services are received; are adequate to meet the clients' needs; and are consistent with good quality of care.

These activities are structured to be in conformance with 1902 (a)(23) and not to duplicate any other service reimbursed in the Medicaid program.

E. Qualification of Providers:

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act.

1. Case Manager Qualifications:

- a. RN licensed in North Carolina with experience in community health nursing or experience in working children and families or
- b. MSW, BSW, or SW meeting State SW, Community Health Assistant qualifications with experience in health and human service or experience in working with children and families or individuals with comparable experience certified by the Department of Environment, Health and Natural Resources as being eligible to provide case management services.

2. Provider Qualifications:

- a. Must have qualified case manager(s)
- b. Must meet applicable state and federal law governing the participation of providers in the Medicaid program.
- c. Must be certified by the Department of Environment, Health and Natural Resources, Maternal and Child Health as a qualified case management provider.

Enrollment is open to all providers who can meet these requirements. In the absence of State licensing laws governing the qualifications and standards of practice for case management services to children, an agreement will be made with the State agency, Department of Environment, Health and Natural Resources, Maternal and Child Health, which has the recognized professional expertise and authority to establish standards that govern case management services for children. As part of the interagency agreement the Department of Environment, Health and Natural Resources, Maternal and Child Health will certify that providers are qualified to render case

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management services in accordance with professionally recognized standards for good care. the purpose of this activity is to help assure that case management services are provided by professionally qualified providers in accordance with section 1902(a)(23) of the Act.

3. Certification Process:

The Section through an MOU with the Division of Medical Assistance will implement methods and procedures to certify all providers for case management to children who can demonstrate:

- a. Their capacity to provide case management services.
- b. Their experience with delivery and/or coordination of services for children.
- c. Their capacity to assure quality.
- d. Their experience in sound financial management and record keeping.

Certification is open to all providers who can meet these requirements.

- F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
 - 1. Eligible recipients will have free choice of the providers of case management services.
 - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Only activities associated with direct services to clients will be considered targeted case management services.

State Plan under Title XIX of the Social Security Act
State/Territory: North Carolina

CASE MANAGEMENT SERVICES
PERSONS WITH HIV DISEASE

- A. Target Group:
Persons who meet the criteria shown in Attachment 1, Item A.
- B. Areas of State in which services will be provided:
X Entire State.
- C. Comparability of Services:
X Service are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirement of section 1902(a)(10)(B) of the Act.
- D. Definition of Services:
Services are defined in Attachment 1, Item D.
- E. Qualifications of Providers:
Qualifications are described in Attachment 1, Item E.
- F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.
 2. Eligible recipient will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

LEVEL OF CARE CRITERIA

4600. General Information

The following criteria are not intended to be the only determinant of the recipient's need for skilled or intermediate care. Professional judgement and a thorough evaluation of the recipient's medical condition and psychosocial needs as well as an understanding of and the ability to differentiate between the need for skilled or intermediate care. Also, the assessment of other health care alternatives should be made as applicable.

4601. Skilled Level of Care Criteria

4601.1 Skilled Nursing Care

Skilled nursing services, as ordered by a physician, must be required and provided on a 24-hour basis, 7 days a week.

Skilled nursing care is that level of care which provides continuously available professional skilled nursing care, but does not require the degree of medical consultation and support services which are available in the acute care hospital. Skilled nursing services are those which must be furnished under the direct supervision of licensed nursing personnel and under the general direction of a physician in order to achieve the medically desired results and to assure quality patient care.

Skilled nursing services include observation and assessment of the total needs of a patient on a 24-hour basis, planning and management of a recorded treatment plan according to that which is established and approved by a physician, and rendering direct services to the patient.

4601.2 Factors Frequently Indicating Need for Skilled Care

1. Twenty-four hour observation and assessment of patient needs by a registered nurse or licensed practical nurse.
2. Intensive rehabilitative services as ordered by a physician, and provided by a physical, occupational, respiratory or speech therapist five times per week or as indicated by therapist.
3. Administration and/or control of medication as required by State law to be the exclusive responsibility of registered or licensed nurses and other specific services subject to such limitation.
4. Twenty-four hour performance of direct services that by physician judgement requires:
 - a. a registered nurse
 - b. a licensed practical nurse, or
 - c. other personnel working under the direct supervision of a registered nurse or licensed practical nurse.
5. Medications: Drugs requiring intravenous, hypodermoclysis or nasogastric tube administration. The use of drugs requiring close observation during an initial stabilization period or requiring nursing skills or professional judgement on a continuous basis, frequent injections requiring nursing skills or professional judgement.
6. Colostomy-Ileostomy: In the stabilization period following surgery and allowing for instruction in self-care.
7. Gastrostomy: Feeding or other tube feedings requiring supervision and observation by licensed nurses.
8. Oxygen therapy: When monitoring need or careful regulation of flow rate is required.
9. Tracheostomy: When twenty-four hour tracheostomy care may be indicated.
10. Radiation Therapy or Cancer Chemotherapy: When case observation for side effects during course of treatment is required.

10. Isolation: When medically necessary as a limited measure because of contagious or infectious disease.
11. Sterile Dressings: Requiring prescription medications and aseptic technique by qualified staff.
13. Decubitus Ulcer(s): When infected or extensive.
14. Uncontrolled Diabetes
15. Conditions which may require SNF care until maximum rehabilitation potential has been reached (time frames may be adjusted according to rehabilitation progress, complications or other pertinent factors):
 - New CVA – within three months
 - New fractured hip - within three months
 - New amputation – within two months or less, adjusted for fitting with prostheses and necessary teaching
 - Comatose
 - Inoperable brain tumor
 - Terminal CA – last stages
 - New myocardial infarction – within two months or less
 - Congestive heart failure – degree of compensation
 - New cholecystectomy – within one month and healing
 - New mastectomy – within 2-3 weeks
 - New pacemaker – within one month
 - New paraplegic/quadruplegic condition
 - Surgical patients – within one month

4601.3 Less Serious Conditions Which Alone May Not Justify Placement at the Skilled Level

Although any one of these conditions alone may not justify placement at the skilled level, presence of several of these factors may justify skilled care. This determination will require careful judgement.

1. Diagnostic Procedures: Frequent laboratory procedures when intimately related to medication administration (such as monitoring anticoagulants, arterial blood gas analysis, blood sugars in unstable diabetics)
2. Medications: Frequent intramuscular injections, routine or PRN medications requiring daily administration and/or judgement by a licensed nurse.
3. Treatments: Required observation, evaluation and assistance by skilled personnel for proper use or patient's safety (e.g., oxygen, hot packs, hot soaks, whirlpool, diathermy, IPPB, etc.).
Skilled procedures including the related teaching and adaptive aspects of skilled nursing are part of the active treatment and the presence of licensed nurses at the time when they are performed is required.
4. Dietary: Special therapeutic diets ordered by a physician and requiring close dietary supervision for treatment or control of an illness, such as chronic renal failure, 0.5 grams or less sodium restrictions, etc.
5. Incontinency: Intense bowel and bladder retraining programs if deemed necessary in accordance with facility procedures.
6. Mental and Behavioral Problems: Mental and behavioral problems requiring treatment or observation by skilled professional personnel, to the extent deemed appropriate for the nursing home.
7. Psychosocial Conditions: The psychosocial conditions of each patient will be evaluated in relation to his/her medical condition when determining a change in level of care. Factors taken into consideration along with the patient's medical needs include age, length of stay in current placement, location and condition of spouse, proximity of social support and the effect of transfer on the patient. It is understood that there can always be, to a greater or lesser degree, some trauma with transfer; even sometimes from one room or hall to

another within the same facility. Whenever a patient/resident exhibits acute psychological symptoms, these symptoms and the need for appropriate services and supervision must have been documented by physician's orders or progress notes, and/or by nursing or therapy notes. Proper and timely discharge planning will help alleviate the fear and worry of transfer.

4602. Intermediate Level of Care Criteria

Intermediate care, as ordered by a physician, must be provided on a 24-hour basis, with a minimum of eight hours of licensed nurse coverage daily. Intermediate care is that level of care which provides daily licensed nursing care, but does not require the 24-hour skilled nursing services required in a skilled nursing facility. ICF services must be furnished under the direction of a physician in order to promote and maintain the highest level of functioning of the patient, and to assure quality patient care.

Intermediate care includes daily observation and assessment of the total needs of the patient by a licensed nurse, planning and management of a recorded treatment plan according to that which is established and approved by a physician, and rendering direct services to the patient. In summary, the philosophy of intermediate care is to maintain patients at their maximum level of self care and independence, prevent regression, and/or return them to a previous level of or new stage of independence.

4602.1 Factors Frequently Indicating Need For Intermediate Care (ICF)

1. Need for daily licensed nurse observation and assessment of patient needs.
2. Need for restorative nursing measures to maintain or restore maximum function, or to prevent the advancement of progressive disabilities as much as possible. Such measures may include, but are not limited to the following:
 - a. encouraging patients to achieve independence in activities of daily living by teaching self care, transfer and ambulation activities.
 - b. use of preventive measures/devices to prevent or retard the development of contractures, such as positioning and alignment, range of motion, use of handrolls and positioning pillows.
 - c. ambulation and gait training with or without assistive devices.
 - d. assistance with or supervision of transfers.
3. Need for administration and/or control of medications which, according to State law, are to be the exclusive responsibility of licensed nurses and any other specific services which are subject to such limitations.
4. Performance of services that by physician judgement require either:
 - a. a licensed nurse a minimum of 8 hours daily; or
 - b. other personnel working under the supervision of a licensed nurse.
5. Medications: The use of drugs for routine and/or maintenance therapy requiring daily observation for drug effectiveness and side effects.
6. Assistance with activities of daily living (i.e., bathing, eating, toileting, dressing, transfer/ambulation), including maintenance of foley catheters and ostomies, supervision of special diets, and proper skin care of incontinent patients.
7. Colostomy – Ileostomy: Maintenance of ostomy patients, including daily monitoring and nursing intervention to assure adequate elimination and proper skin care.
8. Oxygen Therapy: Oxygen as a temporary or intermittent therapy.
9. Radiation Therapy or Cancer Chemotherapy: When a physician determines that daily observation by a licensed nurse is required and adequate.

10. Isolation: When medically necessary on a limited basis because of non-complicated contagious or infectious disease requiring daily observation by licensed personnel, not complicated by other factors requiring skilled care.
11. Dressings: Requiring prescription medications and/or aseptic or sterile technique no more than once daily by licensed staff.
12. Skin Condition:
 - a. decubitus ulcer(c) when not infected or extensive
 - b. minor skin tears, abrasions or chronic skin condition requiring daily observation and/or intervention by licensed personnel.
13. Diabetes: When daily observation of dietary intake and/or medication administration is required for proper physiological control.

4602.2 Illustrative Requirements Which, When Present in Combination, Can Justify Intermediate Level Placement

1. Tracheostomy: When minimal assistance or observation of self care technique is required.
2. Need for teaching and counseling related to a disease process and/or disabilities, diet or medications.
3. Ancillary Therapies: Supervision of patient performance of procedures taught by physical, occupational or speech therapists. This may include care of braces or prostheses and general care of plaster casts.
4. Injections: Given during the hours a nurse is on duty requiring administration and/or professional judgement by a licensed nurse.
5. Treatments: Temporary cast, braces, splint, hot or cold applications, or other appliances requiring nursing care and direction.
6. Psychosocial Considerations: The psychosocial condition of each patient will be evaluated in relation to his/her medical condition when determining a change in level of care. Factors taken into consideration along with the patient's medical needs include age, length of stay in current placement, location and condition of spouse, proximity of social support and the effect of transfer on the patient. It is understood that there can always be, to a greater or lesser degree, some trauma with transfer, even sometimes from one room or hall to another within the same facility. Whenever a patient/resident exhibits acute psychological symptoms, these symptoms and the need for appropriate services and supervision must have been documented by physician's orders or progress notes, and/or by nursing or therapy notes. Proper and timely discharge planning will help alleviate the fear and worry of transfer.
7. Use of protective devices or restraints to assure that each patient is restrained in accordance with the physician's order and that the restrained patient is appropriately evaluated and released at a minimum of every two hours.
8. Other conditions which may require ICF care:
 - Blindness
 - Behavioral problems such as wandering, verbal disruptiveness, combativeness, verbal or physical abusiveness, inappropriate behavior when these can be properly managed in an intermediate care facility.
 - Frequent falls.
 - Chronic recurrent medical problems which require daily observation by licensed personnel for prevention and/or treatment.

Inpatient psychiatric facility services for individuals under 21 years of age.

DEFINITION:

Inpatient psychiatric services for recipients under age 21 must be provided by a psychiatric facility or an inpatient program in a psychiatric facility that meets the following requirements:

- (a) For private owned facilities:
 - (1) A psychiatric hospital or an inpatient psychiatric program in a hospital, accredited by the Joint Commission on Accreditation of Healthcare Organizations, or
 - (2) A psychiatric residential treatment facility which is accredited by the Joint Commission on Accreditation of Healthcare Organizations, or the Council on Accreditation of Services for Families and Children, or the Commission on Accreditation of Rehabilitation Facilities.
- (b) For state owned facilities:
 - (1) A psychiatric residential treatment facility accredited by any other accrediting organization with comparable standards that is recognized by the State DHHS.
 - (2) A psychiatric hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations.

These services are provided before the recipient reaches age 21 or, if the recipient was receiving the services immediately before he or she reached age 21, before the earlier of the following:

- (a) The date he or she no longer requires the services; or
- (b) The date he or she reaches age 22.

CRITERIA FOR MEDICAID COVERAGE OF SERVICES IN A NON ACUTE INTENSIVE
REHABILITATION PROGRAM FOR HEAD INJURY CARE

The state provides head injury care in the most appropriate setting based on medical necessity. This is a separate setting for brain injury care caused by external trauma.

There is a need for a separate rate to be established commensurate with the level of care required to treat this type of patients. Other brain injury care is available in existing NF's thus the need for inclusion is not warranted.

ADMISSION CRITERIA

The admission criteria and continued stay criteria for Medicaid Head-Injury rehabilitation includes the following:

- 1) Diagnosis of brain injury caused by external physical trauma. Cerebral vascular accidents, aneurysms, and congenital defects, which may be temporary or permanent, and cerebral anoxic events disassociated with physical trauma are specifically excluded from this definition.
- 2) Program must be under the direction of a qualified physician.
- 3) Behavior must not be violent. If the patient demonstrate violent behavior, a neuropsychologist or psychiatrist must send additional documentation supporting the need and prognosis of a favorable outcome if given rehabilitation services despite the patient's violent behavior.
- 4) Admission must be approved by the Division of Medical Assistance or a DMA designated agency.
- 5) Medical Necessity
 - i) Must be responsive to verbal, visual, and/or auditory stimuli
 - ii) Medical condition must be stable at time of admission
 - iii) Must not be in deep coma or persistent vegetative state
 - iv) Must have rehabilitation consultation and recommendation by a neurologist, neurosurgeon, the patient's progress and potential for rehabilitation
 - v) Must require and receive at least two of the following therapies a minimum of 15 hours per week in addition to skilled nursing care:
 - Physical Therapy
 - Occupational Therapy
 - Cognitive Therapy
 - Speech Therapy
- 6) Reapproval of stay requires re-evaluation of patient's medical condition and documented rehabilitative progress toward specific functional goals. Reauthorization will be issued by DMA or a DMA designated representative following a re-evaluation of monthly progress summaries for the aforementioned rehabilitative progress. Total length of stay will not be approved for greater than 12 months.

CRITERIA FOR MEDICAID COVERAGE OF SERVICES IN A NON ACUTE INTENSIVE
REHABILITATION PROGRAM FOR HEAD INJURY CARE

DISCHARGE CRITERIA

- 1) Discharge criteria includes:
 - i) Inability or unwillingness of patient and/or family to cooperate with the planned therapeutic program in excess of two consecutive months.
 - ii) Medical complications that preclude intensive rehabilitative effort. An extended period of time for discharge action is not reasonable after established goals have been reached, or a determination made that further progress is unlikely, or that care in a less intensive setting would be appropriate.
 - iii) A length of stay exceeding 12 months.

THERAPEUTIC LEAVE

- 1) Therapeutic leave days must not exceed four (4) days within the patient's length of stay and must be accompanied by written, measurable goals specific for the therapeutic leave.

CRITERIA FOR VENTILATOR-DEPENDENT RECIPIENTS
(Hospital Based or Nursing Facility)

I. Definition

- A. Ventilator dependent is defined by the Division of Medical Assistance as requiring at least sixteen (16) hours/day of mechanical ventilation to maintain a stable respiratory status.

II. Criteria

- A. Recipient's condition must meet the definition of ventilator dependence.
- B. The recipient's condition at time of placement must be stable without infections or extreme changes in ventilatory settings and/or duration (i.e. increase in respiratory rate by 5 breaths per minute, increase in FIO₂ of 25% or more, and/or increase in tidal volume of 200 mls or more).
- C. Admission to a long term care facility must be prior approved.
 - a. Current prior approval forms for Long-Term Care Facilities (FL-2)
 - b. North Carolina Preadmissions and Annual Resident Review (PASARR)
 - c. Admission history and physical and/or Ventilator dependent addendum.

CRITERIA FOR MEDICAID COVERAGE OF NURSE PRACTITIONER SERVICES

Nurse practitioner services means services that

- 1) are provided in accordance with the scope of practice as defined by the State Board of Medical Examiners and Board of Nursing.
- 2) are performed by nurse practitioners who are duly licensed to practice nursing and are approved by the State Board of Medical Examiners and Board of Nursing as “nurse practitioners”; and
- 3) are performed under the supervision of a physician licensed in the State of practice.

COVERAGE LIMITATIONS

Medical services must be performed in accordance with the nurse practitioners scope of practice and signed protocols.

- 1) By Nurse Practitioners in an independent practice i.e. not in the employ of a practitioner, clinic or other service provider for the provision of Nurse Practitioner services.
- 2) For DMA approved procedures developed for use by Nurse Practitioners.
- 3) Subject to the same coverage limitations as those in effect for Physicians.

Medical Care/Other Remedial Care

Services provided under this section are provided by individual practitioners who meet individual practitioner certification standards. Each provider must be certified as meeting program standards of the Department of Health and Human Services. The services are available to the categorically needy and medically needy and include the services described herein.

- A. Generally covered state plan services provided to outpatients by qualified health professional service entities to include prevention, diagnostic, therapeutic or palliative items or services when they are medically necessary.
- 1) Diagnostic services includes medical procedures or supplies recommended by a physician or other licensed practitioner of the healing arts within the scope of his practice that enable him to identify the existence, nature or extent of illness, injury or other health deviation.
 - 2) Screening services includes standardized tests performed under medical direction by qualified health care professionals to a designated population to detect the existence of one or more particular diseases.
 - 3) Preventive services includes services provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to a) prevent disease, disability and other health conditions or their progression b) prolong life and c) promote physical and mental health and efficiency.
 - 4) Therapeutic services means medical care and clinical services for a patient for the purpose of combating disease, injury or other physical/mental disorders by a physician or other qualified practitioner within the scope of practice under state law.
 - 5) Physical therapy occupational therapy and services for individuals with speech, hearing, and language disorders as defined in 42 CFR 440.110. Services are limited to EPSDT eligibles.

- 6) Psychosocial services include assessment, testing, clinical observation and treatment when provided by a psychologist licensed in accordance with state law or certified as a school psychologist by the North Carolina Department of Public Instruction or social worker when certified by the North Carolina Department of Health and Human Services. Services provided are limited to EPSDT eligibles.
- 7) Respiratory therapy services as defined in 1902(e)(9)(A) of the Act when provided by a respiratory therapist licensed under the provisions of the North Carolina Respiratory Care Practice Act. Services provided are limited to EPSDT eligibles.

For EPSDT eligibles, services covered under 1905(r)(5) and as required by 1905 (a) to correct, ameliorate defects and physical and mental illnesses and conditions discovered by screening services whether or not such services are included in the state plan.

Service providers will be offering a comprehensive array of health services to eligible individuals throughout the State of North Carolina and will be offering them in the most appropriate settings possible (for example, schools, homes). All services to an individual are provided as directed in an individualized treatment program by a physician or other licensed practitioner of the healing arts within the scope of his/her practice under state law. The treatment plan also directs the duration and scope of services to be provided in order to achieve the goals and objectives of the plan.

Provision of services where the family is involved will be directed to meeting the identified client's treatment needs. Services provided to non-Medicaid eligible family members independent of meeting the identified client's treatment needs are not covered by Medicaid.

CRITERIA FOR MEDICAID COVERAGE OF CERTIFIED REGISTERED NURSE ANESTHETISTS SERVICES

Certified Registered Nurse Anesthetist Services

- 1) are provided in accordance with the scope of practice as defined by the Nursing Practice Act and rules promulgated by the Board of Nursing, and
- 2) are performed by Certified Registered Nurse Anesthetists who are duly licensed as registered nurses by the State Board of Nursing and are credentialled by the Council on Certification of Nurse Anesthetists as Certified Registered Nurse Anesthetists, and recertified through the Council on Recertification of Nurse Anesthetists, and
- 3) are performed in collaboration with a physician, dentist, podiatrist or other lawfully qualified health care provider and, when prescribing a medical treatment regimen or making a medical diagnosis, are performed under the supervision of a licensed physician.

COVERAGE LIMITATIONS

Medical services must be performed in accordance with the Certified Registered Nurse Anesthetists scope of practice.

1. By Certified Registered Nurse Anesthetists in any practice setting.
2. For DMA approved procedures developed for use by Certified Registered Nurse Anesthetists.
3. Subject to the same coverage limitations as those in effect for Physicians.